

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**0467 CERTIFICATE OF DEATH**

00457

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hinksburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hinksburg</u>			
c. LENGTH OF STAY IN 1b <u>3 1/2 years</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM THOMAS ACKMAN</u> First Middle Last				4. DATE OF DEATH <u>Jan. 30</u> 19 <u>60</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1882</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western High School</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John S. Ackman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Burns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Margaret Ackman - Hinksburg, MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Coma</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Nephrosclerosis Generalized arteriosclerosis</u> (c) <u>Chronic heart failure, Generalized edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>years</u> <u>4</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12 6</u> 19 <u>59</u> to <u>1 30</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>1 27</u> 19 <u>60</u> , and that death occurred at <u>4 30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Sani Okutman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>1 30 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Sani A. Okutman</u>				22d. ADDRESS <u>Sykesville Rd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-2-60</u>		<u>New Cathedral</u>		<u>Baltimore, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sykesville, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 3 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed by a physician who has examined the deceased and is satisfied that death has been caused by the disease or injury stated on the certificate.

**DIRECTOR:** After this certificate has been examined and approved by the Director, it may be detached for use as required by the law for burial or to burial, cremation.

## 0468 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>New Windsor</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> <u>RURAL</u>		c. LENGTH OF STAY IN 1b <u>9 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. 1</u>		d. STREET ADDRESS <u>R.D. 1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE</u> <u>M.</u> <u>ALBERT</u>		4. DATE OF DEATH Month Day Year <u>January</u> <u>21</u> <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 24 1891</u>
9. AGE (In years last birthday) yrs. <u>68</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland, Frederick Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Glass</u>		14. MOTHER'S MAIDEN NAME <u>Cora Horton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>-----</u>	
17. INFORMANT <u>Walter J. Albert</u>		Address <u>New Windsor R.D.1 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>disease</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/11/59</u> , 19 <u>59</u> , to <u>11/21/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/8/60</u> , 19 <u>60</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/21/60</u>	
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>		M.D. <u>New Windsor, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 25 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Linganore</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. WALTZ</u>		ADDRESS <u>Winfield, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JAN 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION



0469

## CERTIFICATE OF DEATH

Reg. Dist. No.

00459

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural) Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN lb. <u>22-5mo. 21da.</u>		d. STREET ADDRESS <u>2309 Arunah Avenue #16</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>Ferdinand</u> Last <u>Arnreich</u>		4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u>	IF UNDER 24 HRS. Hours <u>74</u> Min. <u>74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fish business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>M. Ferdinand Arnreich</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Augusta Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u> INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General paresis.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>60</u> to <u>1-20-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>1-20-60</u> , 19 <u>60</u> , and that death occurred at <u>4:15 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Myron Nizarkowsky</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>1-20-1960</u>	
PHYSICIAN'S NAME (Type) <u>Myron Nizarkowsky, M.D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner &amp; Sons</u> ADDRESS <u>N 1 Pa Ave 17</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
SAN FRANCISCO, CALIFORNIA

IN WITNESS WHEREOF  
I have hereunto set my hand and  
the seal of the Department of Health  
at the City of San Francisco, California,  
this 1st day of January, 1911.

JOHN A. HARRIS  
Registrar

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0470  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>3V01-4</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>Syr. 1mo 2wks</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>Springfield State Hosp</i>		d. STREET ADDRESS <i>1736 N. Port Str.</i>	
3. NAME OF DECEASED (Type or print) <i>Mary Victoria ASKEW</i>		4. DATE OF DEATH Month <i>1</i> Day <i>-9</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-1-1880</i>
9. AGE (In years last birthday) <i>79</i>		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>9</i> Hours <i>15</i> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>h. w.</i>		12. KIND OF BUSINESS OR INDUSTRY <i>No</i>	
13. BIRTHPLACE (State or foreign country) <i>No</i>		14. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. FATHER'S NAME <i>Outlan</i>		16. MOTHER'S MAIDEN NAME <i>?</i>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		18. SOCIAL SECURITY NO. <i>?</i>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHRONIC ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO <i>420.0</i> (b) <i>CHRONIC ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO (c) <i>CHRONIC ARTERIOSCLEROTIC HEART DISEASE</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome with circulatory disturbance with</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (If not, notify medical examiner) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 19</i> , 19 <i>58</i> , to <i>Jan. 9</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan. 9</i> , 19 <i>60</i> , and that death occurred at <i>3:00 P.M.</i> , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <i>Oak Str. Sykesville, Md</i>	
ACTUAL SIGNATURE <i>Konstantin Weber</i> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>KONSTANTIN WEBER M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>1-12-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MORELAND MEM. PARK</i>	22d. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight Inc.</i>		24a. REC'D BY REGISTRAR <i>6009 Harford Rd.</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>		DATE <i>JAN 13 '60</i>	

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TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

DATE OF DEATH  
11-30-41

TIME OF DEATH  
11:00 A.M.

PLACE OF DEATH  
HOSPITAL

CITY  
NEW YORK

COUNTY  
NEW YORK

STATE  
NEW YORK



# Item 1c Film 255 1-27-60 et 0462 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00461

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b> c. LENGTH OF STAY IN 1b <b>2 Weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>47 Frederick Street</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b> d. STREET ADDRESS <b>47 Frederick Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>William</b> Last <b>Aughinbaugh</b>			4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 14, 1908</b>		9. AGE (In years last birthday) <b>51</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Aughinbaugh</b>			14. MOTHER'S MAIDEN NAME <b>Nora Bowman</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>173-03-0699</b>	17. INFORMANT <b>Mrs. Donald W. Auginbaugh, Taneytown, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Artery Occlusion</b> <b>4/6x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic Heart Disease (Chronic)</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Bronchitis, Chronic Lymphatic Leukemia.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/21</b> , 19 <b>60</b> , to <b>1/22</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/22</b> , 19 <b>60</b> , and that death occurred at <b>2:30 A.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>R. S. McVaugh</b>		M.D. <b>49 Frederick St.</b>		DATE SIGNED <b>1/22/60</b>	
PHYSICIAN'S NAME (Type) <b>R. S. McVaugh M.D.</b>		<b>Taneytown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>January 26, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> <b>C. O. Fuss &amp; Son, Taneytown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JAN 25 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0471

## CERTIFICATE OF DEATH

Reg. Dist. No.

00462

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>6Yr.3Mo.15Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland.</b> d. STREET ADDRESS <b>433 East 85 th Street.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Young</b> Last <b>Bachtell</b>		4. DATE OF DEATH Month <b>1-</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-14-72</b>
9. AGE (In years last birthday) <b>87</b>		10. IF UNDER 1 YEAR Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min. <b>87</b>	11. IF UNDER 24 HRS. Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min. <b>87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ezra Young</b>		14. MOTHER'S NAME <b>Editha Goldena Bollar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>	
INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>  <b>Years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS. assoc. with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-16</b> , 19 <b>53</b> , to <b>1-31-</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-31</b> , 19 <b>60</b> , and that death occurred at <b>2-30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Iise Kamm</b> M.D.		ADDRESS (Street, city or town, state) <b>Sykesville, Md.</b> DATE SIGNED <b>1-31-60</b>	
PHYSICIAN'S NAME (Type) <b>Iise Kamm</b> M. D.		Sykesville, Md.	
22a. BURIAL, CREMATION, REBURY (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Feb. 2. 1960</b>	<b>Blue Ridge Cemetery</b>	<b>Thurmont, Fredk. Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>		24a. REC'D BY REGISTRAR <b>Thurmont, Md</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58



## 0472 CERTIFICATE OF DEATH

00463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>13yrs.9mos.4days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS -			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>John H. Barncord</b>				4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1883</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Barncord</b>				14. MOTHER'S MAIDEN NAME <b>Martha Gomer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. -			
17. INFORMANT <b>Springfield Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, paranoid type.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b> <b>Years.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>January 3, 1960</b> , that I last saw the deceased alive on <b>January 3, 1960</b> , and that death occurred at <b>10:10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>1/4/60</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				SYKESVILLE, MARYLAND.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-8-60</b>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <b>Beltsville</b>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harold S. Howell</b>				24a. REC'D BY REGISTRAR <b>DATE JAN 12 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

515

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VS A15 (4)  
15M 9/58

STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Usual residence: \_\_\_\_\_

7. Date of death: \_\_\_\_\_

8. Time of death: \_\_\_\_\_

9. Cause of death: \_\_\_\_\_

10. Place of death: \_\_\_\_\_

11. Signature of attending physician: \_\_\_\_\_

12. Signature of registrar: \_\_\_\_\_

13. Date of registration: \_\_\_\_\_



MEDICAL CERTIFICATION

VS A15 (4)  
ISM 9/SB

STATE OF TEXAS  
CERTIFICATE OF DEATH

No. \_\_\_\_\_

County of \_\_\_\_\_ State of \_\_\_\_\_

Deceased \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_

Occupation \_\_\_\_\_

Place of Birth \_\_\_\_\_

Residence \_\_\_\_\_

Cause of Death \_\_\_\_\_

Time of Death \_\_\_\_\_

Place of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

## 0474 CERTIFICATE OF DEATH

Reg. Dist. No.

00465

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pleasant Valley</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pleasant Valley</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Blanche</u> Last <u>Black</u>				4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1874</u>	9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward M. Hahn</u>				14. MOTHER'S MAIDEN NAME <u>Laura Devilbiss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Mr. Edward M. Black, Westminster, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x cerebral hemorrhage</u> DUE TO (b) <u>arterio-sclerosis</u> DUE TO (c) <u>senility</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days ago and 10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 4</u> , 19 <u>60</u> to <u>Jan. 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 4</u> , 19 <u>60</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. B. Billingslea</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Westminster, Md. 1-6-60</u>			
PHYSICIAN'S NAME (Type) <u>C. B. Billingslea</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 8, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pleasant Valley, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jan 8 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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MD  
515

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0476

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00467

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>15Yr. 3Mo. 7Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lavinia</b> Middle <b>BOWERS</b> Last <b>BOWERS</b>		4. DATE OF DEATH Month <b>1-</b> Day <b>31-</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>05</b> Days <b>05</b> Hours <b>05</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mathias Roop</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Vogel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriolosclerotic Heart Disease</b> DUE TO (c) <b>Senile psychosis, simple deterioration.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis, simple deterioration.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-24-44</b> , 19 <b>44</b> , to <b>1-31</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-31</b> , 19 <b>60</b> , and that death occurred at <b>3-508</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ilse Kamm</b>		ADDRESS (Street, city or town, state) <b>Sykesville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Ilse Kamm M.D.</b>		DATE SIGNED <b>1-31-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-26-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Park Cem</b>		22d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Goulson</b>		ADDRESS <b>7359 Washington Blvd</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kamm</b>	

2000 2001 2002 2003 2004

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0462 CERTIFICATE OF DEATH

Reg. Dist. No. 00468

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>313 East Baltimore Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Elizabeth</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 16, 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William G. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Harman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Tobias O. Brown, Taneytown, Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) <b>Essential Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>14 yrs</b> <b>16 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Cholecystitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 12, 1955</b> to <b>Jan 28, 1960</b> that I last saw the deceased alive on <b>Jan 22, 1960</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Ambler Thompson</b> M.D.		ADDRESS (Street, city or town, state) <b>Taneytown, Md</b> DATE SIGNED <b>1/29/60</b>	
PHYSICIAN'S NAME (Type) <b>E. Ambler Thompson</b>		<b>Taneytown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 1, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son,</b>		ADDRESS <b>Taneytown, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF  
CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Cause of death: \_\_\_\_\_  
8. Signature of physician: \_\_\_\_\_  
9. Signature of registrar: \_\_\_\_\_  
10. Date of registration: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00469

Reg. Dist. No.

0477

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>30yrs. 1mo. 24days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Md.</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>2022 Rayner Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward H. Brown</b>			4. DATE OF DEATH Month Day Year <b>January 12, 1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>		9. AGE (In years last birthday) <b>66</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown JOHN H BROWN</b>			14. MOTHER'S MAIDEN NAME <b>Unknown IDA JONES</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> <b>570.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paresis.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Carroll Co</b>	(County) <b>MD</b>	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/12/60</b>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/15/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SAMS CREEK</b>	22d. LOCATION (City, town, or county) <b>CARROLL CO</b>	(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hartzler &amp; Sons</b>		ADDRESS <b>New Windsor, Md</b>		24a. REC'D BY REGISTRAR <b>Jan 20 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0478 CERTIFICATE OF DEATH

Reg. Dist. No. 00470

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEADOW VIEW CONVS. HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD HENRY BROWN</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 17 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 8 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TOBACCO SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D. JOSHUA BROWN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH BANKERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. CHAS. F. MAGEE, WESTMINSTER MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>CHRONIC PYELONEPHRITIS</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u> <u>3 YRS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCTOBER 1952</u> , to <u>JANUARY 17 1960</u> , that I last saw the deceased alive on <u>JANUARY 14, 1960</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Stewart,</u> M.D.		ADDRESS (Street, city or town, state) <u>19 RIDGE RD.</u> DATE SIGNED <u>1/17/60</u>	
PHYSICIAN'S NAME (Type) <u>William L. Stewart, M.D.</u>		<u>WESTMINSTER, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>JAN. 20, 60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>KRIDER'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>RURAL WESTMINSTER MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Timpson, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0479 CERTIFICATE OF DEATH

00471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Sykesville</b> c. LENGTH OF STAY IN 1b <b>1 year</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Grand View Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Finksburg</b> d. STREET ADDRESS <b>Deer Park Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Henry Conaway</b>		4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1879</b>
9. AGE (In years last birthday) <b>80</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Conaway</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Schafer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-24-9806</b>	
17. INFORMANT <b>Mrs. Lillie P. Conaway</b>		Address <b>Finksburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE with</b> <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>X</b> <b>ARTERIOSCLEROSIS, GENERALIZED</b> <b>X</b> <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20yrs</b> <b>20yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>21 April</b> , 19 <b>59</b> , to <b>2 January</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1 January</b> , 19 <b>59</b> , and that death occurred at <b>2:00A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John H. Lawson, Jr.</b>		ADDRESS (Street, city or town, state) <b>Liberty Road at Eldersburg</b>	
PHYSICIAN'S NAME (Type) <b>John H. Lawson, Jr., M.D.</b>		DATE SIGNED <b>1.2.60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-4-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Providence Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Gamber, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Maryland</b>	
24a. REC'D BY REGISTRAR <b>Jan 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE OF DEATH

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

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TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9 Film 6254 1-8-60 et

0480

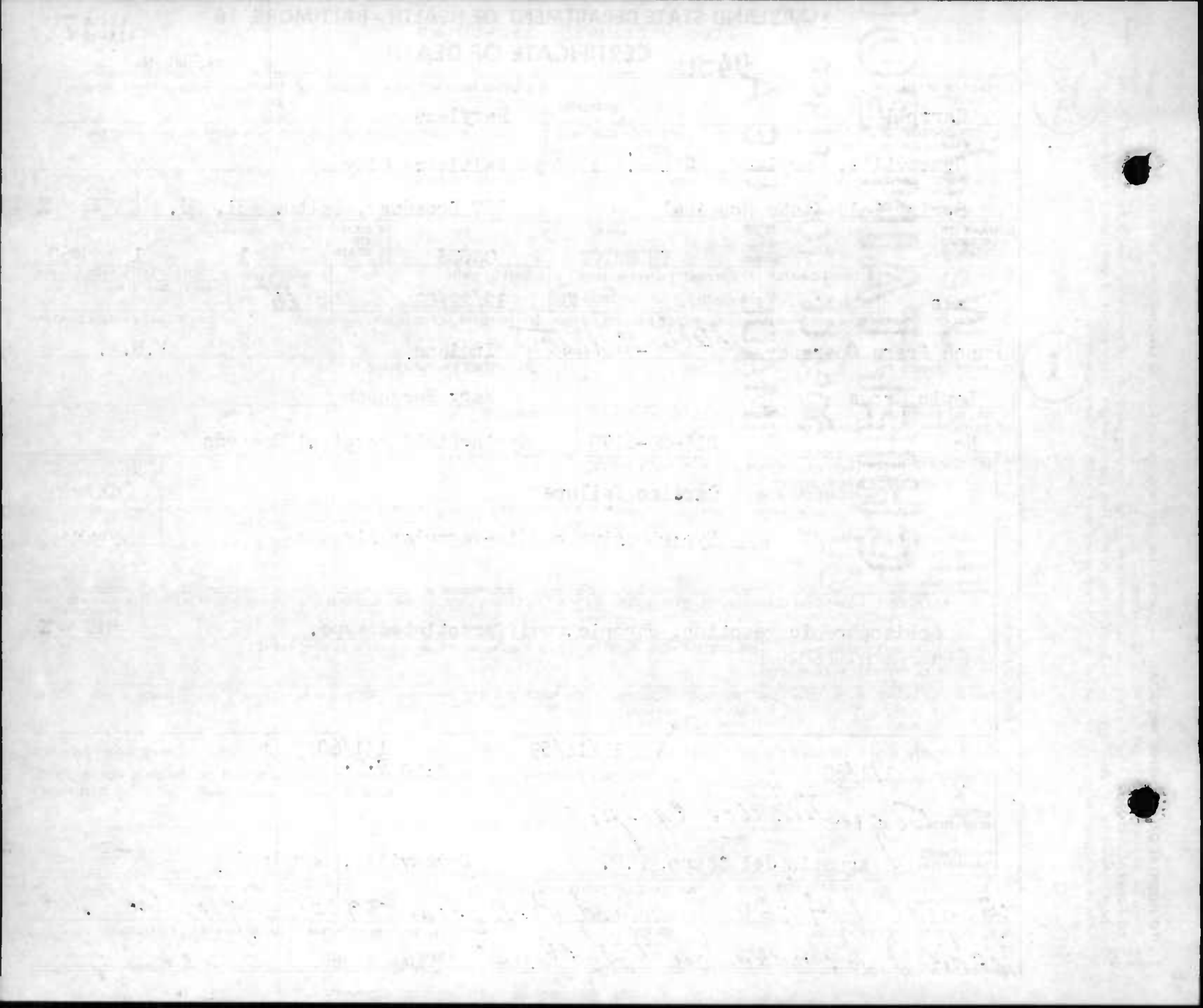
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Maryland</b> c. LENGTH OF STAY IN lb <b>3 yrs. 15 mos. 15 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3V01-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>227 Broadway, Balto. #31, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>PERRY THORNTON CROSS</b>			4. DATE OF DEATH Month Day Year <b>1 1 1960</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12/22/02</b>	9. AGE (In years last birthday) <b>57</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Punch Press Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Lewis Cross</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ferguson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-09-6179</b>		
17. INFORMANT <b>Springfield Hospital Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardio-vascular disease</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, chronic undifferentiated type.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>11/14/59</b> , 19____, to <b>1/1/60</b> , 19____, that I lost saw the deceased alive on <b>1/1/60</b> , 19____, and that death occurred at <b>2:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.					
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/4/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>2905 Taylor Ave Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Bowman</b>			24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		
ADDRESS <b>20 Hollins St.</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hanna</b>		





0487

## Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)  
ISM 10/57



may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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0482

CERTIFICATE OF DEATH

00474

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2mos. 5days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Blaine</b> Last <b>Easton</b>				4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 2, 1889</b>	
9. AGE (In years lost birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Easton</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Shipley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-01-6557</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery thrombosis</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> C.B.S.assoc.with cerebral arteriosclerosis.				INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Days</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>C.B.S.assoc.with cerebral arteriosclerosis.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 14, 1959</b> to <b>January 19, 1960</b> , that (I) (we) last saw the deceased alive on <b>January 18, 1960</b> and that death occurred at <b>6:50AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-21-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>				ADDRESS <b>Winfield, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>139 CITY VIEW AVE.</u>		d. STREET ADDRESS <u>139 CITY VIEW AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GILBERT REESE EBAUGH</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 20 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 10, 1908</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MILL WORK</u>	11. BIRTHPLACE (State or foreign country) <u>CARLTON MARYLAND U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JOSEPH ALLEN EBAUGH</u>		14. MOTHER'S MAIDEN NAME <u>STELLA REESE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>216-03-9193</u>	
17. INFORMANT <u>Wife - MRS. GILBERT EBAUGH - WESTMINSTER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCTOBER, 1954</u> , to <u>JANUARY 20, 1960</u> , that I last saw the deceased alive on <u>JANUARY 16, 1960</u> , and that death occurred at <u>4:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Stewart, M.D.</u>		ADDRESS (Street, city or town, state) <u>19 RIDGE RD.</u>	
DATE SIGNED <u>1/20/60</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM L. STEWART, M.D.</u>		<u>WESTMINSTER, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LEISTER'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, CARROLL, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James G. Saffell</u>		ADDRESS <u>WESTMINSTER, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>James G. Saffell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0483 CERTIFICATE OF DEATH

00476

1. PLACE OF DEATH a. COUNTY <b>Ca roll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>M. yland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 m 12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Isabelle</b> Last <b>Eckenrode</b>		4. DATE OF DEATH Month <b>1</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Fem</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-21-83</b>
9. AGE (In years last birthday) <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Eckenrode</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Roddy</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>S.S.Hospital Records</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of Right external iliac artery</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>CBS assoc.with unknown origin</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc.with unknown origin</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 5, 1960</b> to <b>Jan. 16, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 16, 1960</b> , and that death occurred <b>4:10 PM</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Edmund Lusthaus</b>		22b. DATE SIGNED <b>1-16-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		22d. ADDRESS <b>Springfield State Hoapital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 20, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Nr. Emmitsburg Fredk. Co. MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. P. Creager &amp; Son</b> ADDRESS <b>Thurmont MD</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 19 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>		25c. REGISTRAR'S NAME	

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]  
12. Place of registration: [illegible]

## 0484 CERTIFICATE OF DEATH

Reg. Dist. No.

00477

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>1,548 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alexander Felder</b>		4. DATE OF DEATH Month Day Year <b>January 22 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-28-30</b>
9. AGE (In years last birthday) <b>29 yrs.</b>		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Manning, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Willie Felder</b>		14. MOTHER'S MAIDEN NAME <b>Christien Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Alexander Felder</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Far advanced bilateral pulmonary tuberculosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 27, 1955</b> to <b>January 22, 1960</b> , that I last saw the deceased alive on <b>January 22, 1960</b> , and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. M. Maculans</b> M.D.		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>1-22-60</b>	
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M.D.</b>		HENRYTON STATE HOSPITAL, HENRYTON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		DATE <b>JAN 25 '60</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ORIGINAL FILED

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Bennell</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Court Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>URITH - IRENE - FOWBLE</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>OH</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Fowble</u>		14. MOTHER'S MAIDEN NAME <u>Susan Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>710</u>	
17. INFORMANT <u>Mr Randle Cole - Hanpstead Md</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anteroseptal Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydronephrosis of kidney</u> (b) <u>Small Pox</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>May 1950</u> , 19 <u>50</u> , to <u>Jan 18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>60</u> , and that death occurred at <u>5 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foward</u>		ADDRESS (Street, city or town, state) <u>Manchester, MD</u>	
PHYSICIAN'S NAME (Type) <u>W H Foward MD.</u>		DATE SIGNED <u>1-19-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grace Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw D. Dighton</u>		ADDRESS <u>Hanpstead Md</u>	
24a. REC'D BY REGISTRAR <u>JAN 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

M

090

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1902

State of New York  
County of ...  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the ... day of ... 1902, at the place named above, I attended ... who died at the age of ... years, of the disease of ... the result of ...  
Witness my hand and the seal of my office this ... day of ... 1902.  
Signature of Physician  
My Commission Expires ...  
Attest:  
Notary Public for the State of New York  
My Commission Expires ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0485 CERTIFICATE OF DEATH

00479

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4yrs. 4mos. 1day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>RFD #1, 10 A,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Fuller</b>		4. DATE OF DEATH Month <b>January</b> Day <b>29,</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 15, 1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Francis Fuller</b>		14. MOTHER'S MAIDEN NAME <b>Ella Stewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 28, 19 55</b> to <b>January 29, 19 60</b> , that (I) (we) last saw the deceased alive on <b>January 28, 19 60</b> , and that death occurred at <b>8:30AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edmund Lusthaus</b> M.D.		22b. DATE SIGNED <b>1/29/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/1/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 2 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

0447

DATE: 11/11/54

0447

TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report. The text is mostly illegible due to fading and bleed-through from the reverse side of the page.]

1

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0486 CERTIFICATE OF DEATH

00480

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>15 y 5m 17 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> 0102-2	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Monroe</b> Last <b>Gannon</b>		4. DATE OF DEATH Month <b>1</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/27</b>
9. AGE (In years last birthday) <b>32</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>23</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John R. Gannon</b>		14. MOTHER'S MAIDEN NAME <b>Gladys Gannon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unkn</b>	
17. INFORMANT <b>S.S. Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, far advanced</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>002x</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental deficiency, without psychosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-20-1954</b> to <b>1-23-60</b> , that (I) (we) last saw the deceased alive on <b>1-23-1960</b> , and that death occurred at <b>1:30PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edmund Lusthaus</b>		22b. DATE SIGNED <b>1-23-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 26, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Right</b>		25a. REC'D BY REGISTRAR <b>JAN 26 '60</b>	
ADDRESS <b>Cumberland Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

11-18-11

STATE OF NEW YORK  
OFFICE OF THE COMMISSIONER OF HEALTH  
BUREAU OF VITAL STATISTICS

NAME: [illegible] SEX: [illegible] AGE: [illegible] RACE: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]

DATE OF INTERMENT: [illegible] PLACE OF INTERMENT: [illegible]  
NAME OF FUNERAL HOME: [illegible]

NAME OF PHYSICIAN: [illegible]  
NAME OF NURSE: [illegible]

NAME OF HOSPITAL: [illegible]

DATE OF REPORT: [illegible] BY: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

NAME OF PHYSICIAN: [illegible]  
NAME OF NURSE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0487 CERTIFICATE OF DEATH

00481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Sykesville</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>	
		d. STREET ADDRESS <b>R.D. 2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>KATIE E. GIST</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>7,</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Linton</b>		14. MOTHER'S MAIDEN NAME <b>Annie M. Frost</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. Herbert Layton, Damascus, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Infarction</b> DUE TO (c) <b>Today</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Hemorrhage 1957 with Partial Blindness</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1958</b> , to <b>Jan 7, 1960</b> , that I last saw the deceased alive on <b>Jan 6, 1960</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Carroll Co., Md.</b> DATE SIGNED <b>Jan 7-60</b>			
ACTUAL SIGNATURE <b>MORRELL N. MARTIN</b> M.D.			
PHYSICIAN'S NAME (Type) <b>MORRELL N. MARTIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-9-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Freedom</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b> ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 11 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1991



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00482

0488 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6yr. 5mo. 14da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSPITAL</b>		d. STREET ADDRESS <b>3004 Cresmont Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Stella Bowme Sprague GRAHAM</b>		4. DATE OF DEATH <b>January 8 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-28-72</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Steven Sprague</b>		14. MOTHER'S MAIDEN NAME <b>Sara Sprague</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Coronary thrombosis with acute heart failure and terminal pneumonia;</b> DUE TO (b) <b>Arteriosclerotic heart disease .</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-24</b> , 19 <b>53</b> , to <b>1-8</b> , 19 <b>60</b> , that I lost saw the deceased alive on <b>1-8</b> , 19 <b>60</b> , and that death occurred at <b>2:00P</b> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ilse Kamm</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>1-8-60</b>	
PHYSICIAN'S NAME (Type) <b>Ilse Kamm, M. D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>1-11-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>Baltimore</b>	
24a. REC'D BY REGISTRAR <b>JAN 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00483

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5y. 11 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>E.</b> Last <b>HAHN</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-5-1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min.	11. IF UNDER 24 HRS. Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Seacrist</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT Address <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with senile brain disease, with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7</b> , 19 <b>55</b> , to <b>January 5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 5</b> , 19 <b>60</b> , and that death occurred at <b>6:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		DATE SIGNED <b>1-5-60</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ereghon Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Gettysburg Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald Petrus 321 Calish St Gettysburg Pa</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 8 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

*[Faint, illegible text visible through the paper]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00484

Reg. Dist. No.

0490

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u> c. LENGTH OF STAY IN 1b <u>5 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Manchester - Rural</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester - Rural</u> d. STREET ADDRESS <u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>ROBERT</u> First <u>LAUER</u> Middle <u>HALE</u> Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>4. DATE OF DEATH</b> <u>Jan 22</u> 19 <u>60</u> Month Day Year	
<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb 15-1922</u> <b>9. AGE</b> (In years last birthday) <u>37</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>MD</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>William Hale</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W-W-#2-220-40-5436</u> <b>16. SOCIAL SECURITY NO.</b> <u>W-W-#2-220-40-5436</u> <b>17. INFORMANT</b> <u>Mrs Nora Schaeffer-Hale</u> Address <u>Manchester</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Hilda Lauer</u> <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASPHYXIA</u> <u>916.0</u> DUE TO (b) <u>HOUSE TRAILER FIRE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>House trailer burned</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>1-22-60</u> Hour <u>4</u> a.m. p.m. <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town) (County) (State)</b> <u>Manchester Carroll MD</u>		<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></b> <b>ACTUAL SIGNATURE</b> <u>James J. Marsh</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>JAMES T. MARSH</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>1/22/60</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>1-26-1960</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Balto National Cem</u> <b>22d. LOCATION (City, town, or county) (State)</b> <u>Baltimore MD</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edw &amp; Tipton - Hampstead Md</u> ADDRESS _____ <b>24a. REC'D BY REGISTRAR</b> <u>JAN 27 '60</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>William L. Knecht</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00485

## 0491 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>35yrs7mths11dys</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 311</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2814 Waterview Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle Last <b>Herion</b>		4. DATE OF DEATH Month <b>1</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease.</b> 420.0 DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional Psychotic Reaction</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-7-</b> <b>1955</b> , to <b>1-3-</b> <b>1960</b> , that I last saw the deceased alive on <b>1-3-</b> <b>1960</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
DATE SIGNED <b>1-3-1960</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		ADDRESS <b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-6-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. [Signature]</b>		ADDRESS <b>367 Chestnut Ave.</b>	
24a. REC'D BY REGISTRAR <b>Jan 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Clifford L. [Signature]</b>	

OFFICE OF THE ATTORNEY GENERAL

MEMORANDUM

TO :

FROM :

SUBJECT :

RE :

DATE :

BY :

FOR :

Enclosed for the Department of Health and Welfare are two copies of a report of the State Board of Health regarding the results of the health survey conducted in the State of New York during the year 1954.

The report is being submitted to you for your information and for your review and comment.

Very truly yours,

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0492 CERTIFICATE OF DEATH

00486

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural --Westminster</b>		c. LENGTH OF STAY IN 1b <b>19 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at Winfield</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>D.</b> Last <b>KEEFER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>74</b>	11. IF UNDER 24 HRS. Days <b>74</b> Hours <b>74</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer, -- retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Keefer</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Shriner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b>		16. SOCIAL SECURITY NO. <b>219-20-4130</b>	
17. INFORMANT <b>Mrs. Ruth A. Keefer,</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x</b> DUE TO <b>Bronchial pneumonia, Cardiac failure.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral hemorrhage, rt side hemiplegia</b> DUE TO <b>Anteromedullary generalized</b> (c) <b>Anteromedullary generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Jan 60</b> <b>27 Jan 60</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1960</b> to <b>27 Jan 1960</b> , that (I) (we) last saw the deceased alive on <b>27 Jan 1960</b> , and that death occurred at <b>8:40 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Howard E. Hall</b>		22b. DATE <b>1-27-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>HOWARD E. HALL M.D.</b>		22d. ADDRESS <b>SYKESVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-30-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer, Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll, Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz</b>		ADDRESS <b>Winfield, Maryland</b>	
25a. REC'D BY REGISTRAR <b>JAN 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>C. M. Waltz</b>	

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

5-11-83

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0460

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HANOVER</u> 75 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>A</u> Last <u>Ketterman</u>		4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Market</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Ketterman</u>		14. MOTHER'S MAIDEN NAME <u>Susan Shue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>199-14-2466</u>	
17. INFORMANT <u>Mrs Ella Ketterman</u>		Address <u>HANOVER PA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic Cardiovascular Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JAN 17, 1960</u> , to <u>JAN 20, 1960</u> , that I last saw the deceased alive on <u>January 18, 1960</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		DATE SIGNED <u>1/20/60</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>HAMPSTEAD MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>HANOVER, York Co. Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0493 CERTIFICATE OF DEATH

00488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>9yrs. 8mos. 8days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>2524 Park Heights Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Sophia</b> Middle Last <b>Laff</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 7, 1908</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Ydah Laff</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Cowan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right ventricular hypertrophy</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Tuberculous fibrosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, hebephrenic type.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>January 11, 1960</b> , that I last saw the deceased alive on <b>January 11, 1960</b> , and that death occurred at <b>12:10 P.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustini del Campo</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital 1/11/60</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 13-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSEDALE</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc - 2100 E. E. Place</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 13 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

CENTRAL AVE OF DRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00489

0494 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>5 mo. 24 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Ernest</b> Last <b>LaMotte</b>		4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>1960</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-19-1888</b>		9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Edward LaMotte</b>				14. MOTHER'S MAIDEN NAME <b>Lula E. Myerly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS associated with chronic alcoholism plus cerebral arteriosclerosis hemiplegia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>8-5-59</b> to <b>1-29</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>1-29</b> 19 <b>60</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edmund Lusthaus</b>				22b. DATE <b>1-29-60</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Edmund Lusthaus</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-2-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emory Methodist</b>		23d. LOCATION (City, town, or county) <b>Carroll Co Md</b> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edwin S. Lipton</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 2 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fuller's Graves Creek</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elmer</i> Middle <i>LIPPY</i> Last <i>LIPPY</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>2</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/23/77</i> 9. AGE (In years last birthday) <i>82</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carroll Co. Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin B. Lippy</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth M. Thentz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Woodbury</i>	
17. INFORMANT <i>Woodbury</i>		Address <i>Manchester, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest, Arteriosclerotic heart disease</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension, rt. hemiplegia - bronchial</i> DUE TO (c) <i>pneumonia</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <i>6-20-59 to 2 Jan 60</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-20</i> , 19 <i>59</i> , to <i>2-1</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2-1</i> , 19 <i>60</i> , and that death occurred at <i>10:05 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward E. Hall</i>		ADDRESS (Street, city or town, state) <i>Sykesville, Md</i> DATE SIGNED <i>2 Jan 60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>1/5/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Manchester</i>		22d. LOCATION (City, town, or county) (State) <i>Manchester, Md Carroll</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur B. Buckner</i>		ADDRESS <i>Manchester, Md</i>	
24a. REC'D BY REGISTRAR <i>Arthur E. Hall</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hall</i>	
DATE <i>JAN 5 '60</i>			

CERTIFICATE OF DEATH

Form No. 10-1

1. NAME OF DECEASED MAYNARD		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 1891	
5. PLACE OF BIRTH Maryland		6. OCCUPATION Retired		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH 1958	
13. TIME OF DEATH 10:00 AM		14. PLACE OF INTERMENT Catholic Cemetery		15. NAME OF CLERGYMAN Father [Name]		16. NAME OF FUNERAL HOME [Name]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF PHYSICIAN [Signature]		20. SIGNATURE OF CLERK [Signature]	
21. NAME OF PHYSICIAN [Name]		22. NAME OF CLERK [Name]		23. NAME OF FUNERAL HOME [Name]		24. NAME OF CLERGYMAN [Name]	
25. NAME OF PLACE OF INTERMENT [Name]		26. NAME OF CLERGYMAN [Name]		27. NAME OF FUNERAL HOME [Name]		28. NAME OF CLERK [Name]	
29. NAME OF PHYSICIAN [Name]		30. NAME OF CLERK [Name]		31. NAME OF FUNERAL HOME [Name]		32. NAME OF CLERGYMAN [Name]	
33. NAME OF PLACE OF INTERMENT [Name]		34. NAME OF CLERGYMAN [Name]		35. NAME OF FUNERAL HOME [Name]		36. NAME OF CLERK [Name]	
37. NAME OF PHYSICIAN [Name]		38. NAME OF CLERK [Name]		39. NAME OF FUNERAL HOME [Name]		40. NAME OF CLERGYMAN [Name]	
41. NAME OF PLACE OF INTERMENT [Name]		42. NAME OF CLERGYMAN [Name]		43. NAME OF FUNERAL HOME [Name]		44. NAME OF CLERK [Name]	
45. NAME OF PHYSICIAN [Name]		46. NAME OF CLERK [Name]		47. NAME OF FUNERAL HOME [Name]		48. NAME OF CLERGYMAN [Name]	
49. NAME OF PLACE OF INTERMENT [Name]		50. NAME OF CLERGYMAN [Name]		51. NAME OF FUNERAL HOME [Name]		52. NAME OF CLERK [Name]	
53. NAME OF PHYSICIAN [Name]		54. NAME OF CLERK [Name]		55. NAME OF FUNERAL HOME [Name]		56. NAME OF CLERGYMAN [Name]	
57. NAME OF PLACE OF INTERMENT [Name]		58. NAME OF CLERGYMAN [Name]		59. NAME OF FUNERAL HOME [Name]		60. NAME OF CLERK [Name]	
61. NAME OF PHYSICIAN [Name]		62. NAME OF CLERK [Name]		63. NAME OF FUNERAL HOME [Name]		64. NAME OF CLERGYMAN [Name]	
65. NAME OF PLACE OF INTERMENT [Name]		66. NAME OF CLERGYMAN [Name]		67. NAME OF FUNERAL HOME [Name]		68. NAME OF CLERK [Name]	
69. NAME OF PHYSICIAN [Name]		70. NAME OF CLERK [Name]		71. NAME OF FUNERAL HOME [Name]		72. NAME OF CLERGYMAN [Name]	
73. NAME OF PLACE OF INTERMENT [Name]		74. NAME OF CLERGYMAN [Name]		75. NAME OF FUNERAL HOME [Name]		76. NAME OF CLERK [Name]	
77. NAME OF PHYSICIAN [Name]		78. NAME OF CLERK [Name]		79. NAME OF FUNERAL HOME [Name]		80. NAME OF CLERGYMAN [Name]	
81. NAME OF PLACE OF INTERMENT [Name]		82. NAME OF CLERGYMAN [Name]		83. NAME OF FUNERAL HOME [Name]		84. NAME OF CLERK [Name]	
85. NAME OF PHYSICIAN [Name]		86. NAME OF CLERK [Name]		87. NAME OF FUNERAL HOME [Name]		88. NAME OF CLERGYMAN [Name]	
89. NAME OF PLACE OF INTERMENT [Name]		90. NAME OF CLERGYMAN [Name]		91. NAME OF FUNERAL HOME [Name]		92. NAME OF CLERK [Name]	
93. NAME OF PHYSICIAN [Name]		94. NAME OF CLERK [Name]		95. NAME OF FUNERAL HOME [Name]		96. NAME OF CLERGYMAN [Name]	
97. NAME OF PLACE OF INTERMENT [Name]		98. NAME OF CLERGYMAN [Name]		99. NAME OF FUNERAL HOME [Name]		100. NAME OF CLERK [Name]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE FUNERAL HOME AND THE CLERGYMAN.

CLERK OF DISTRICT COURT

DATE



## 0496 CERTIFICATE OF DEATH

00491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>near Carrollton</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE REBECCA LONG</u>				4. DATE OF DEATH Month Day Year <u>JAN. 25 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Bliss Houck</u>				14. MOTHER'S MAIDEN NAME <u>Martha Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mr. Noah J. Long</u> Address <u>Carrollton Post office Westminster Md. Rd.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331x</u> DUE TO (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>with my father's</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 25, 1957</u> to <u>Jan 25, 1960</u> that I last saw the deceased alive on <u>Jan 25, 1960</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D.				ADDRESS (Street, city or town, state) <u>15 Kemper Ave</u> DATE SIGNED <u>1/26/60</u>			
PHYSICIAN'S NAME (Type) <u>E. Reese Wilkens</u>				<u>Westminster Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 28, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carrollton Church of God</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Liz Myers Jr.</u> ADDRESS <u>Westminster Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 28 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Charles B. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained for use in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0497 CERTIFICATE OF DEATH

00492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>47y.7m.3d.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>LORDO</b> Last <b>LORDO</b>				4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1885</b>	
9. AGE (In years last birthday) <b>74?</b> yrs.		IF UNDER 1 YEAR Months <b>74?</b> Days <b>74?</b> Hours <b>74?</b> Min. <b>74?</b>		IF UNDER 24 HRS. Months <b>74?</b> Days <b>74?</b> Hours <b>74?</b> Min. <b>74?</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b> ✓	
13. FATHER'S NAME <b>James Lordo</b>				14. MOTHER'S MAIDEN NAME <b>Unk.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		INFORMANT Address <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Nephrosclerosis</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>General arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, other and unspecified.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7</b> , 19 <b>55</b> , to <b>January 5</b> 19 <b>60</b> , that I last saw the deceased alive on <b>January 5</b> , 19 <b>60</b> , and that death occurred at <b>3:15 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustini del Campo</b>		M.D. <b>Springfield State Hospital</b>		ADDRESS (Street, city or town, state) <b>1-5-60</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-6-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Haight</b>				ADDRESS <b>Sykesville, Md.</b>		24a. RECEIVED BY REGISTRAR <b>JAN 11 1960</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haight</b>	

CERTIFICATE OF DEATH

State of New York

County of \_\_\_\_\_

City of \_\_\_\_\_

State of New York

Decd.

Decd.

Age

Age

Sex

Sex

Color

Color

Mar.

Mar.

Prof.

Prof.

Rel.

Rel.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0498 CERTIFICATE OF DEATH

00493

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Maryland</b> c. LENGTH OF STAY IN 1b <b>9 hours</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore, #18 Maryland</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2720 Hugo Ave.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jeanette L. Macauley</b>				4. DATE OF DEATH Month Day Year <b>1 11 1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/17/1888</b>	
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>MARION LINDSAY</b>				14. MOTHER'S MAIDEN NAME <b>LAURA J. LEVERTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myocardial infarction</b> DUE TO (c) <b>Arteriosclerotic cardio-vascular disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>hours</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1/11/60</b> 19____, to <b>1/11/60</b> 19____, that (I) (we) last saw the deceased alive on <b>1/11/60</b> 19____, and that death occurred at <b>8:55 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. SANDER &amp; SONS INC. BALTIMORE MD.</b>				25a. REC'D BY REGISTRAR <b>JAN 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

10-1-50

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
0222 CERTIFICATE OF DEATH

Date of Birth		Date of Death	
Place of Birth		Place of Death	
Sex		Race	
Marital Status		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Report		Date of Entry	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G255 2-1-60 et

0499

## CERTIFICATE OF DEATH

00494

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Union Mills</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Meadow View Convalescent Home</b>		e. STREET ADDRESS <b>R. 4 Reese</b>	
3. NAME OF DECEASED (Type or print) <b>Ella First Blanche Last BLANCHE ELLHA MAGEE</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1869</b>
9. AGE (In years last birthday) yrs. <b>90</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles W. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Tawney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>	
17. INFORMANT <b>John L. Magee</b>		Address <b>R 4 Westminster, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>1 MONTH</b> <b>10 YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JULY</b> , 1959, to <b>JANUARY 26</b> , 1960, that I last saw the deceased alive on <b>JANUARY 25, 1960</b> , and that death occurred at <b>9:35 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Lewis Stewart</b>		ADDRESS (Street, city or town, state) <b>19 RIDGE RD.</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM LEWIS STEWART</b>		DATE SIGNED <b>1/26/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-29-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sandymount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sandymount, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JAN 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <b>JOHN L. WARD, JR.</b></p>		<p>2. Date of death: <b>April 17, 1960</b></p>	
<p>3. Place of death: <b>Home</b></p>		<p>4. Cause of death: <b>Heart Disease</b></p>	
<p>5. Age at death: <b>45</b></p>		<p>6. Sex: <b>Male</b></p>	
<p>7. Race: <b>White</b></p>		<p>8. Marital status: <b>Married</b></p>	
<p>9. Occupation: <b>Engineer</b></p>		<p>10. Education: <b>High School</b></p>	
<p>11. Date of birth: <b>April 17, 1915</b></p>		<p>12. Place of birth: <b>Baltimore, Md.</b></p>	
<p>13. Name of physician: <b>Dr. J. H. Smith</b></p>		<p>14. Name of hospital: <b>None</b></p>	
<p>15. Name of funeral home: <b>None</b></p>		<p>16. Name of cemetery: <b>None</b></p>	
<p>17. Name of informant: <b>John L. Ward, Jr.</b></p>		<p>18. Address of informant: <b>1234 Main St., Baltimore, Md.</b></p>	
<p>19. Signature of informant: <b>[Signature]</b></p>		<p>20. Signature of physician: <b>[Signature]</b></p>	
<p>21. Date of completion: <b>April 18, 1960</b></p>		<p>22. Name of registrar: <b>John L. Ward, Jr.</b></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0500  
CERTIFICATE OF DEATH

00495

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>			
c. LENGTH OF STAY IN 1b <i>23 years</i>				d. STREET ADDRESS <i>Thudow Road</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>CLAYTON THOMAS MARRINER</i>				4. DATE OF DEATH <i>Jan. 26 19 60</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 16, 1892</i>	
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>P. R. R.</i>			
11. BIRTHPLACE (State or foreign country) <i>Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Francis Wm Mariner</i>				14. MOTHER'S MAIDEN NAME <i>Sarah P. Miller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>717-07-6133</i>			
17. INFORMANT <i>Mrs Rachel Mariner - Sykesville, Md.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage, coronary thrombosis,</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac failure, arteriosclerosis</i> DUE TO (c) <i>generalized</i> INTERVAL BETWEEN ONSET AND DEATH <i>1957 to 26 Jan 60</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> 19 to <i>26 Jan</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>26 Jan</i> 19 <i>60</i> and that death occurred at <i>6:50 P</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard E. Hall</i>				22b. DATE SIGNED <i>1-27-60</i>			
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>				22d. ADDRESS <i>Sykesville, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>1-29-60</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Memorial Gardens</i>				23d. LOCATION (City, town, or county) (State) <i>Frederick County, Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Haight</i>				25a. REC'D BY REGISTRAR <i>FEB 2 '60</i>			
ADDRESS <i>Sykesville, Md.</i>				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00496

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3yrs.5mos.15days</b> <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>508 N. Eutaw St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Pauline</b> Last <b>(Jenkins) Masel</b>				4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 1, 1883</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>August Maselkowski</b>				14. MOTHER'S MAIDEN NAME <b>Pauline Suwalski</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral accident</b> DUE TO <b>Pulmonary tuberculosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>002X</b> (c) <b>002X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Week</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>August 7, 19 56</b> to <b>January 22, 19 60</b> , that (H) (we) last saw the deceased alive on <b>January 21, 19 60</b> , and that death occurred at <b>1:10AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				22b. DATE <b>1/22/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Sykesville, Md. - Springfield Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 25/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>London Rd.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herweg Sons Orlemonst.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 26 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

DATE

FILE NO.

DECEASED

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

TIME OF DEATH

CAUSE OF DEATH

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0502

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>4500 Harford Rd. Balto. #14</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH MARION REPP McEIROY</b>				4. DATE OF DEATH Month Day Year <b>1 1 1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/23/72</b>	9. AGE (In years lost birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Repp</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia left side</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Cardiac failure</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>12/30/59</b> , 19____, to <b>1/1/60</b> , 19____, that I last saw the deceased alive on <b>1/1/60</b> , 19____, and that death occurred at <b>11:10 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>1/1/60</b> ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Sykesville, Maryland</b> PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>1-4-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Swartz Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>			24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0383 CIVIL AIR OF DEATH

73

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hampstead</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GARNET - A - MILLER</u>		4. DATE OF DEATH <u>Jan 29</u> 19 <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7 - 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stuck</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>W.B.A.</u>	
13. FATHER'S NAME <u>William H Ruby</u>		14. MOTHER'S MAIDEN NAME <u>Hester Stansbury</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>266-22-1793</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Repeated Thromboses for past three years.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/25/60</u> , 19____, to <u>1/29/60</u> , 19____, that I last saw the deceased alive on <u>1/25</u> , 19 <u>60</u> , and that death occurred at <u>11:45 A</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		DATE SIGNED <u>1/29/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 1 - 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		22d. LOCATION (City, town, or county) <u>Carroll co Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton - Hampstead Md</u> ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>FEB 2 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1925

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

REPORTED BY

SIGNATURE

NAME

REGISTERED

DATE

FILE NO.

REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00493

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge Rural - 20 1/20</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Union Bridge Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
3. NAME OF DECEASED (Type or print) <u>RAYMOND - L - MINNICK</u>		4. DATE OF DEATH <u>January 15 - 19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Minnick</u>		14. MOTHER'S MAIDEN NAME <u>Mary Blocher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>13-12-9049</u>	
17. INFORMANT <u>Mrs Raymond Minnick - Union Bridge Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/1/57</u> , 19____, to <u>1/15/60</u> , 19____, that I last saw the deceased alive on <u>1/14/60</u> , 19____, and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.E. Robertson</u> M.D.		ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>1/15/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1-19-1960</u>	<u>Ripe Creek Can</u>	<u>Carroll Co - Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. G. Gorton - Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

THE JOURNAL OF THE  
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ON BEHALF OF THE INSTITUTE  
LONDON AND WASHINGTON, D.C.



## 0505 CERTIFICATE OF DEATH

Reg. Dist. No.

00500

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt Airy</u>			c. LENGTH OF STAY IN 15 <u>1 mo.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Watersville Road</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Delano</u> Middle <u>Roosevelt</u> Last <u>Myers, Jr.</u>			4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3, 1959</u>	9. AGE (In years last birthday) <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Delano Roosevelt Myers</u>			14. MOTHER'S MAIDEN NAME <u>Clara Bernice Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	INFORMANT <u>Mrs Clara Myers</u> Address <u>Mt Airy</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>491x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>                    </u> DUE TO (c) <u>                    </u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>                    </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1/21</u> , 19 <u>60</u> to <u>1/22</u> , 19 <u>60</u> that I last saw the deceased alive on <u>1/22</u> , 19 <u>60</u> , and that death occurred at <u>3:58</u> PM, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>900 So Main St</u>		DATE SIGNED <u>1/22/60</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		<u>Mt. Airy, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/24/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Simpson Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Poplar Springs, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mohrmanth</u>		ADDRESS <u>Damascus, Md.</u>	24a. REC'D BY REGISTRAR <u>JAN 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

1. Name of deceased: [illegible]  
2. Age: [illegible]  
3. Sex: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of declarant: [illegible]  
10. Date of statement: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00501

0506

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westminster</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>X Rural Westminster</b>	
3. NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>Theodore</b> Last <b>Myers</b>		4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 21, 1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore J. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Koontz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-8328</b>	
17. INFORMANT <b>Mrs. Norman T. Myers, Route #7, Westminster, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension &amp; Coronary</b> DUE TO (c) <b>Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Glen Speicher</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Acting</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1/25/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 28, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Kriders Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> ADDRESS <b>C.O. Fuss &amp; Son, Taneytown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>			

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>	RACE <i>White</i>
DATE OF DEATH <i>1/25/60</i>		TIME OF DEATH <i>10:00 AM</i>	PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>123 Main St, Baltimore, Md</i>		OCCUPATION <i>Teacher</i>		
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		
DISEASES PRESENT <i>Coronary Artery Disease</i>		DISEASES PRESENT <i>None</i>		
SIGNATURE OF EXAMINER <i>[Signature]</i>		DATE <i>1/25/60</i>		
OFFICIAL SEAL		OFFICIAL SEAL		

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00502

050

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sylkesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sylkesville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>EARL SYLVESTER NORRIS</i>				4. DATE OF DEATH <i>Jan. 23 1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 19 1903</i>	9. AGE (In years last birthday) <i>56</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Road Construction</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James O. Norris</i>				14. MOTHER'S MAIDEN NAME <i>Eliza Combash</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>220-03-2157</i>		17. INFORMANT <i>Mrs. Mabel Norris - Sylkesville, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary 7 liver, aneurysm, renal -</i> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>malnutrition, bronchial pneumonia -</i> DUE TO (c) <i>23 Jan 60</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1958 to</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> 19 to <i>23 Jan</i> 19, that (I) (we) last saw the deceased alive on <i>23 Jan</i> 1960, and that death occurred at <i>8P</i> M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard E. Hall</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1-25-60</i>			
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		22d. ADDRESS <i>Sylkesville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1-26-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St Luke's</i>		23d. LOCATION (City, town, or county) (State) <i>Sylkesville, Carroll, Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>				25a. REC'D BY REGISTRAR <i>FEB 2 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

100-100

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00503

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>38yrs.6mos.17days</b> <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>913 Arlington Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Annie A. Youse Peters</b>		4. DATE OF DEATH <b>January 15, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dressmaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Youse</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Lockland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Pulmonary tuberculosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b> <b>Years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive reaction, manic type.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1955</b> to <b>January 15, 1960</b> , that (H) (we) last saw the deceased alive on <b>January 15, 1960</b> , and that death occurred at <b>4:18 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustini del Campo</b>		22b. DATE SIGNED <b>1/15/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/18/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC</b>		25a. REC'D BY REGISTRAR <b>715 LIGHT ST</b>	
25b. REGISTRAR'S SIGNATURE <b>John F. Denny</b>		DATE <b>JAN 18 '60</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Rudolph</b> Last <b>Phelps</b>		4. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-81</b>
9. AGE (In years birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshua Q. Rudolph Phelps</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Boyce Carpenter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. INFORMANT <b>Hospital records</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>C.B.S. associated with senile brain disease, with psychotic reaction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>12-16</b> , 19 <b>59</b> , to <b>1-2</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-2</b> , 19 <b>60</b> , and that death occurred at <b>10.30 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		ADDRESS (Street, city or town, state) <b>Sykesville Maryland</b>	
DATE SIGNED <b>1-3-60</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>		<b>Springfield State Hospital.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 5, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 5 '60</b>	
ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0200

Deceased

Age

Sex

Married

Occupation

Residence

Place of birth

Place of death

Signature

Signature

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 14 Film G255 2-4-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

00505

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 mo. 20 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albina</b> Middle <b>Praglowski</b> Last <b>Praglowski</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-19-1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (In years, months, days) <b>63</b>
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Bilek</b>		14. MOTHER'S MAIDEN NAME <b>Anna Fialkowski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Bronch-pneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Chronic Brain Syndrome of unknown cause</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>Aug. 20, 1959</b> , to <b>Jan. 10, 1960</b> that I last saw the deceased alive on <b>Jan. 9, 1960</b> , and that death occurred at <b>4:45 A.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Flores</b>		ADDRESS (Street, city or town, state) <b>Sykesville - 1-10-60</b>	
PHYSICIAN'S NAME (Type) <b>Joseph Flores, M.D.</b>		DATE SIGNED <b>1-10-60</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Buried Jan 13/60 Holy Rosary</b>		22b. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Ozogowski</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 12 '60</b>	
ADDRESS <b>1930 Eastern</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECLARATION OF DEATH

Declarant

Relationship

Residence

Signature

Signature

Date

Place

Place

County

County

State

Witness

Notary Public

Notary Public

1-1-0

1-1-0

1-1-0

1-1-0



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00506

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">0511</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u> d. STREET ADDRESS <u>✓</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>INFANT</u> Middle <u>BOY</u> Last <u>PRATER</u>		<b>4. DATE OF DEATH</b> Month <u>JAN</u> Day <u>26</u> Year <u>1960</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan 26 - 1960</u>
<b>9. AGE</b> (In years last birthday) <u>5 yr.</u>		<b>IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>10</u>	<b>IF UNDER 24 HRS.</b> Hours <u>10</u> Min. <u>10</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NO</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Paul R Prather</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Bonathy Cumber</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>	
<b>17. INFORMANT</b> <u>Paul R Prater, Hampstead Md</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATALECTASIS</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH _____	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>James T. Marsh</u>		<b>DATE SIGNED</b> <u>1/26/60</u>	
<b>EXAMINER'S NAME (Type)</b> <u>JAMES T MARSH</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>	<b>22b. DATE THEREOF</b> <u>1-26-60</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St Paul's</u>	<b>22d. LOCATION (City, town, or county) (State)</b> <u>Balto Co Md</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edw E. Hipton</u>		<b>24a. REC'D BY REGISTRAR</b> <u>FEB 1 1960</u>	
<b>ADDRESS</b> <u>Hampstead Md</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Marsh</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG254 1-20-60 et

CERTIFICATE OF DEATH

00597

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westminster</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>I.</b> Last <b>Reifsnider</b>		4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 8, 1878</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James F. Yingling</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Waltman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Claude B. Reifsnider, Westminster, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension &amp; arteriosclerotic</b> DUE TO (c) <b>Cardio Renal disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b> <b>5-6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 16</b> , 19 <b>59</b> , to <b>Jan 13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 13</b> , 19 <b>60</b> , and that death occurred at <b>7:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>		ADDRESS (Street, city or town, state) <b>Westminster Md</b>	
PHYSICIAN'S NAME (Type) <b>W. Glenn Speicher, Westminster, Maryland</b>		DATE SIGNED <b>1/14/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 16, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b>		ADDRESS <b>Taneytown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0513

## CERTIFICATE OF DEATH

Reg. Dist. No.

00508

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENEDUM ST</u>		d. STREET ADDRESS <u>BENEDUM ST</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROLINE ELIZA RICKETTS</u>		4. DATE OF DEATH Month Day Year <u>JAN. 21 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 JUNE 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM FRITZ</u>		14. MOTHER'S MAIDEN NAME <u>EMMA MOPPS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>212-40-5268</u>	
17. INFORMANT Address <u>MRS WILSON HARRIS UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right hemiparesis; Right renal calculus; aortic stenosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/15/60</u> , 19 <u>59</u> , to <u>1/21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/21/60</u> , 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. CARICOFF</u>		DATE SIGNED <u>1/21/60</u>	
PHYSICIAN'S NAME (Type) <u>J. H. CARICOFF</u>		<u>UNION BRIDGE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/24/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE CEM</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Hartzler</u>		ADDRESS <u>Union Bridge Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0465

## CERTIFICATE OF DEATH

00509

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27/1 Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>68 1/2 Bond St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAGGIE ESTELLE RINEHART</u>				4. DATE OF DEATH Month Day Year <u>JAN. 20 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John T. Hesson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Harner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Liberty St. C. EARL RINEHART, Westminster Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A. S. C. V DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-20</u> , 19 <u>55</u> , to <u>1-20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-20</u> , 19 <u>60</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>1-21-60</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>				LOCATION (City, town, or county) (State) <u>WESTMINSTER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan. 23, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek, Cemetery New Windsor Md RD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Meyers, Jr., Westminster, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0514  
CERTIFICATE OF DEATH

00510

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2yrs. 8mos. 15days</b> <b>Baltimore 14</b> <b>3V01-4</b>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>4307 Mainfield Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Elizabeth Dunn Roberts</b>				4. DATE OF DEATH Month Day Year <b>January 24, 1960</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 16, 1872</b>		9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>				11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Dunn</b>				14. MOTHER'S MAIDEN NAME <b>Cornelia Rickey</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>				17. INFORMANT Address <b>Springfield Hospital Records</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pericardial tamponade</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Rupture of left descending coronary artery</b> DUE TO (c) <b>Recent myocardial infarction</b>												INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>24 hrs.</b> <b>3 days.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase.</b>														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 9, 1957</b> to <b>January 24 1960</b> , that (I) (we) last saw the deceased alive on <b>January 24 60</b> and that death occurred at <b>12:30 PM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Agustini del Campo</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>1/25/60</b>							
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/26/60</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5305 Harford Road #14</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 26 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



## 0515 CERTIFICATE OF DEATH

00511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LINEBORO</b>				c. LENGTH OF STAY IN 1b <b>14 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LINEBORO</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>WARNER</b> Last <b>RUPP</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 18, 1881</b>	
9. AGE (In years lost birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPING</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>CARROLL Co. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>HENRY F. WARNER</b>				14. MOTHER'S MAIDEN NAME <b>LYDIA MILLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-18-7388</b>		17. INFORMANT <b>WM. J. L. RUPP</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>General Arteriosclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3-4 weeks</b> <b>3-4 years</b> <b>8 - 10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July</b> , 19 <b>36</b> , to <b>Jan. 22</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 22</b> , 19 <b>60</b> , and that death occurred at <b>3:20p</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M. C. Porterfield</b> M.D.				ADDRESS (Street, city or town, state) <b>Hampstead, Md.</b>			
PHYSICIAN'S NAME (Type) <b>M. C. Porterfield</b>				DATE SIGNED <b>1-23-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>JAN. 25, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>UNION</b>	
22d. LOCATION (City, town, or county) (State) <b>LINEBORO, MD.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. C. Porterfield</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Farris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







0516

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3mos. 27days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Frank</b> Last <b>Rychwalski</b>				4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1890</b>	9. AGE (In years lost birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stanislaus Rychwalski</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Pietrowicz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-arteriosclerosis</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with trauma.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 9, 1959</b> , to <b>January 6, 1960</b> that I last saw the deceased alive on <b>January 5, 1960</b> , and that death occurred at <b>2:10A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital</b> <b>1/6/59</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital</b>					
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		Sykesville, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 9, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		22d. LOCATION (City, town, or county) (State) <b>Dundalk Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda 2829 Hudson St. 24, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Orlino L. Hume</i>	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

0462

CERTIFICATE OF DEATH

00513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WILLIAM - ROSS - SHOWER</u> First Middle Last		4. DATE OF DEATH <u>Jan 1</u> Month Day Year 19 <u>60</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20 - 1987</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H Shower</u>		14. MOTHER'S MAIDEN NAME <u>May Ross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>420-16-4093</u>	
17. INFORMANT <u>Mrs Wm. P. Shower</u>		Address <u>Manchester, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 - Acute Renal Failure</u> DUE TO (b) <u>Anterosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 31</u> , 19 <u>59</u> , to <u>Jan 1</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Dec 31</u> , 19 <u>59</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Ford</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md</u>	
PHYSICIAN'S NAME (Type) <u>W H Ford MD</u>		DATE SIGNED <u>1/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 3/60</u>	<u>Manchester</u>	<u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin S. Pipton</u>		ADDRESS <u>Hamstead Md</u>	
24a. REC'D BY REGISTRAR <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

1901

1901

Dec 24 1901  
New York City

WILLIAM J. HAYES - 72 years  
born 1829 - died 1901  
at his residence, 123 West 12th St., New York City

Dec 24 1901  
New York City  
WILLIAM J. HAYES - 72 years  
born 1829 - died 1901  
at his residence, 123 West 12th St., New York City  
Dec 24 1901  
New York City  
WILLIAM J. HAYES - 72 years  
born 1829 - died 1901  
at his residence, 123 West 12th St., New York City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0517

CERTIFICATE OF DEATH

00514

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>11yrs. 11mos. 22days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 30.</b>		d. STREET ADDRESS <b>1915 Breitwert Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Elizabeth</b> Last <b>Sifter</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9,</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 23, 1919</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <b>40</b> Days <b>40</b> Hours <b>40</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Sifter</b>		14. MOTHER'S MAIDEN NAME <b>Caroline - MAYER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Springfield Hospital Records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Cerebralvascular accident (old)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental deficiency, imbecile level without psychosis, plus epilepsy.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>January 9, 1960</b> that I last saw the deceased alive on <b>January 9, 1960</b> , and that death occurred at <b>3:00P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>1/9/60</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>13 JAN 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WESTERN Cem</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Toulson</b>		ADDRESS <b>7359 Wash Blvd</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>		c. LENGTH OF STAY IN 1b <b>3yr. 6m. 20d.</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3701.4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Unknown 531 Gutman Ave</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Loane</b> Last <b>Small</b>		4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>19 60</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-1-77</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Gustave Loane</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		
INFORMANT <b>Springfield State Hospital record</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome, associated with disturbance of metabolism growth or nutrition, with senile brain disease with psychotic reaction</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>November 18, 1958</b> , to <b>1-29</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-29</b> , 19 <b>60</b> , and that death occurred at <b>7:40</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oak Street</b> DATE SIGNED ACTUAL SIGNATURE <b>Konstantin Weber</b> M.D. PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M.D.</b> <b>Sykesville, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-1-60</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook Blight Inc. 6009 Harford Rd. 14.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 8 '60</b>		
24b. REGISTRAR'S SIGNATURE <i>Christina A. ...</i>				

*Redgworth*

*Re 6-4162*

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**0519 CERTIFICATE OF DEATH**

00516

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 311</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2yrs. 9mths. 28dys.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Adam</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>1</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-22-1884</b>	
9. AGE (In years and birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>30</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>30</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George Smith</b>				14. MOTHER'S MAIDEN NAME <b>Catherine France</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>212-14-6729</b>		17. INFORMANT <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO <b>Coronary artery thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <b>Hypertensive arteriosclerotic heart disease</b> (c) <b>Chronic brainsyndrome asso. with cerebral arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b> <b>years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brainsyndrome asso. with cerebral arteriosclerosis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>1-30-</b>				20g. (County) <b>1-30-</b>		20h. (State) <b>1-30-</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4-2-</b> <b>1957</b> to <b>1-30-</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>1-30-</b> <b>1960</b> , and that death occurred at <b>10.35p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo.</b>				22b. DATE SIGNED <b>1-31-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo.</b>				22d. ADDRESS <b>Springfield state Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 3rd 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Belair Road Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leo W Cook</b>				25a. REC'D BY REGISTRAR <b>1701 Cathman Pl Baltimore</b>		25b. REGISTRAR'S SIGNATURE <b>DATE FEB 1 '60</b>	

may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shysville</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>117 Oak St.</u>		d. STREET ADDRESS <u>117 Oak St.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles William Smith</u>		<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>19</u> Year <u>1960</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>March 19 1902</u>
<b>9. AGE</b> (In years last birthday) <u>57</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	<b>11. IF UNDER 24 HRS.</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Morris Furniture Co.</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>Harvey Smith</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ella Wheatley</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Mrs. Gertrude Smith - Shysville, Md.</u>		<b>Address</b> <u>  </u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, Circumflex</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diox. alcoholism severe.</u> DUE TO (c) <u>  </u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1957 and 19 Jan 60</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1957</u> <b>19</b> <u>Jan</u> <b>1960</b> <b>that (I) (we) last saw the deceased alive on</b> <u>19 Jan 1960</u> <b>and that death occurred at</b> <u>5:00 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Howard E. Hall</u>		<b>22b. DATE SIGNED</b> <u>20 Jan 60</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>HOWARD E. HALL</u>		<b>22d. ADDRESS</b> <u>Shysville, Md.</u>	
<b>23a. BURIAL, CREMATION, or REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>1-22-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Oakland</u>	<b>23d. LOCATION (City, town, or county)</b> (State) <u>Oakland Rd. Carroll Co., Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur A. Haight</u>		<b>25a. REGISTRY REGISTRAR</b> <b>DATE</b> <u>JAN 22 60</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>			

1. Name of deceased: *Howard E. Hall*  
2. Sex: *Male*  
3. Age: *1-20-00*  
4. Date of death: *April 10, 1918*  
5. Place of death: *at home*  
6. Cause of death: *influenza*  
7. Signature of physician: *Howard E. Hall*  
8. Signature of registrar: *Howard E. Hall*  
9. Date of registration: *April 10, 1918*  
10. Place of registration: *at home*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00518

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>64 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NEAR DENNING</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GUERNIE L. STULLER</u>		4. DATE OF DEATH Month Day Year <u>JAN. 16 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 3, 1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WESTMINSTER, MD. RA#5</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JESSE T. STULLER</u>		14. MOTHER'S MAIDEN NAME <u>LEANNAH LINDSAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-36-8175</u>	
17. INFORMANT <u>MRS. G. L. STULLER</u>		Address <u>WESTMINSTER, MD. RA#5</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE FROM BLADDER</u> 289.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>AMYLOID INFILTRATION OF LIVER</u> DUE TO (c) <u>PRIMARY AMYLOIDOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>6 MOS</u> <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 17, 1959</u> , to <u>JANUARY 16, 1960</u> , that I last saw the deceased alive on <u>JANUARY 16, 1960</u> , and that death occurred at <u>2:49 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William J. Stewart</u>		ADDRESS (Street, city or town, state) <u>19 RIDGE RD.</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM L. STEWART</u>		DATE SIGNED <u>1/16/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 19, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD. RA#5</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Murphy, Westminster, Md.</u>		24. REC'D BY REGISTRAR <u>DATE N 20 60</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00519

## 0522 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thiernau</b> Last <b>Thiernau</b>		4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown 7/27/83</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown John Thiernau</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Adelaide Schade</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 27, 1959</b> to <b>January 3, 1960</b> , that I last saw the deceased alive on <b>January 3, 1960</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>1/4/60</b> ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital</b> PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/6/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wash. Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Switzerland road</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. 1400 Chapin St. N.W.</b>		24a. REC'D BY REGISTRAR <b>JAN 7 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

6592 - CERTIFICATE OF DEATH

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0466

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>27 Westminster</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>820 E. Baltimore Blvd.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Bertha E. Tillman</i>		4. DATE OF DEATH Month Day Year <i>Jan. 14 1960</i>	
5. SEX <i>F.</i>	6. COLOR OF RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10, 1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13. FATHER'S NAME <i>Samuel Ringerfelter</i>		14. MOTHER'S MAIDEN NAME <i>Janie Lucken</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unk.</i>	
17. INFORMANT <i>Mr. Edward E. Tillman</i>		Address <i>as above.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocarditis - De compensating</i> (c) <i>Hypertension + Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>5 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 minutes</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-1-45</i> to <i>1-14-60</i> , that I last saw the deceased alive on <i>1-12-60</i> , and that death occurred at <i>1:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James S. Saffell</i> M.D.		ADDRESS (City or town, state) <i>Reisterstown, Md.</i> DATE SIGNED <i>1-14-60</i>	
PHYSICIAN'S NAME (Type) <i>James G. Saffell MD</i>		<i>Reisterstown, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>1-16-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Oakland</i>	22d. LOCATION (City, town, or county) (State) <i>Westminster, Carroll Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>		24. REC'D BY REGISTRAR <i>Arthur S. Hume</i>	
ADDRESS <i>Westminster, Md.</i>		DATE <i>JAN 19 1960</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





0523

CERTIFICATE OF DEATH

Reg. Dist. No.

00521

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long Meadows Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William H. Tillman</u>		4. DATE OF DEATH Month Day Year <u>Jan 13 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Dept. Balt. City</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chas. W. Tillman</u>		14. MOTHER'S MAIDEN NAME <u>Carrie H. Boyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW1</u>		16. SOCIAL SECURITY NO. <u>213-28-1692</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>ARTERIOSCLEROTIC CV DISEASE</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH. <u>5 MIN.</u> <u>10 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN. 3</u> , 19 <u>55</u> , to <u>JAN. 13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>DEC. 14</u> , 19 <u>59</u> , and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Schaefer</u> M.D.		ADDRESS (Street, city or town, state) <u>401 RANDOM ROAD</u> DATE SIGNED <u>1/14/60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER</u>		<u>BALTO. 29 MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Macraft &amp; Son</u> ADDRESS <u>Catonville 28</u>		24a. REC'D BY REGISTRAR <u>JAN 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0524

## CERTIFICATE OF DEATH

Reg. Dist. No.

00522

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN 1b <b>19 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dunkirk</b> d. STREET ADDRESS <b>04X-2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James William Wallace</b>				4. DATE OF DEATH Month Day Year <b>Jan. 4, 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-7-1903</b>	9. AGE (In years last birthday) yrs. <b>56</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Wallace</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Creek</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-12-4958</b>		INFORMANT Address <b>James Wm. Wallace - Patient</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Carcinoma of the right lung</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 16, 1959</b> to <b>Jan. 4, 1960</b> , that I last saw the deceased alive on <b>Jan. 4, 1960</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Henryton, Maryland 1-4-60</b> ACTUAL SIGNATURE <b>Edgars M. Maculans</b> M.D. <b>Henryton, Maryland</b> PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>1-7-60</b>		<b>1-7-60</b>		<b>110th St.</b>		<b>AA Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>P. E. Sewell Prince Frederick Md</b>				24a. REC'D BY REGISTRAR <b>JAN 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. E. K.</b>	

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

County of Carroll, State of Maryland

Henryton, 19 days in January

Henryton State Hospital

James William Wallace, 60 years of age

Male, Negro, 8-7-1903

Formerly of the U. S. Army

John Wallace, Henryton Creek

211-1-4978 James W. Wallace - Patient

Cardiovascular Anomalies

Coronary of the right lung

Jan. 10, 1950, 11:00 AM

Henryton, Maryland

Dr. Edgar M. McManus, M.D., Henryton State Hospital, Henryton, Md.

## 0525 CERTIFICATE OF DEATH

Reg. Dist. No. 74

00523

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton, Maryland</b>		c. LENGTH OF STAY IN 1b <b>224 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Savaniel</b> Last <b>Warner</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-5-1897</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Trappe, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Warner</b>		14. MOTHER'S MAIDEN NAME <b>Rosa McLaughlin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Raymond S. Warner - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Lymphatic leukemia</b> DUE TO (c) <b>Pleurisy with effusion left.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 26</b> , 19 <b>59</b> , to <b>Jan. 5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 5</b> , 19 <b>60</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>1-5-1960</b>			
ACTUAL SIGNATURE <b>Edgars M. Maculans, M.D.</b>		M.D. <b>Henryton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D.</b>		<b>Henryton State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-10-60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Trappe Am.</b>		22d. LOCATION (City, town, or county) (State) <b>Trappe Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Parrish, Eastern Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Anthony L. Kneass</b>			

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

Decedent's Name: John Warner

Age: 50 Sex: Male

Place of Birth: Massachusetts

Usual Residence: 123 Main St, Boston, Mass

Date of Death: Jan 25, 1950

Time of Death: 10:30 AM

Place of Death: Home

Cause of Death: Chronic Myocarditis

Manner of Death: Natural

Physician's Signature: [Signature]

Medical Examiner's Signature: [Signature]

Registrar's Signature: [Signature]

Witness's Signature: [Signature]

Death Certificate Number: 100-1-1000

Registration Date: Jan 25, 1950

Registration Office: Boston, Mass

Registration District: 1-1-1000

Registration Office: Boston, Mass

Registration District: 1-1-1000

Registration Office: Boston, Mass

*[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]*

*[Handwritten notes at the bottom of the page:]*  
James E. [illegible]  
[illegible]  
[illegible]



## 0526 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3y. 1m. 29d.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>JOHN</b> Last <b>WORTECK</b>				4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-16-1893</b>	
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Worteck</b>				14. MOTHER'S MAIDEN NAME <b>Margaret</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-26-2197</b>			
17. INFORMANT Address <b>Records, Springfield State Hospital</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemorrhage of abdominal aneurysm</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes.</b>  <b>Years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>November 6, 1956</b> to <b>January 5, 1960</b> , that I last saw the deceased alive on <b>January 5, 1960</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>1-5-60</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral Jan 9/60</b>				22b. DATE THEREOF <b>Jan 9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herweg Sons Orleans St</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 11 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

052

## CERTIFICATE OF DEATH

Reg. Dist. No.

00525

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 1, Westminster, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle <b>---</b> Last <b>ZEPP</b>		4. DATE OF DEATH Month <b>1</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/1/93</b> <del>About 1895</del>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>The Family Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Zepp</b>		14. MOTHER'S MAIDEN NAME <del>Unknown</del> <b>Ida Heltibridle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b> INFORMANT Address <b>Springfield State Hospital Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>422.2</b> DUE TO <b>Chronic degenerative myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, simple type in a mental defective</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 18</b> , 19 <b>58</b> , to <b>1-21-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-21-</b> , 19 <b>60</b> , and that death occurred at <b>11:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oak Street</b> DATE SIGNED <b>Konstantin Weber</b> ACTUAL SIGNATURE <b>Konstantin Weber</b> M.D. <b>Sykesville, Maryland</b> PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/24/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Bartholomew Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Nr. Hanover, York Co., Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 25 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hearn</b>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 14 1964

U.S. AIR FORCE

OFFICE OF THE

JOINT CHIEFS OF STAFF

WASHINGTON, D.C.

MEMORANDUM

TO: THE SECRETARY OF DEFENSE

FROM: THE JOINT CHIEFS OF STAFF

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

0-252

CENTRAL AID DE BUREAU

052